MAC*facts*

Key Findings on Medicaid and CHIP

April 2013

Medicaid Managed Care

Over the past two decades, managed care has emerged as the dominant way for organizing and delivering services for most Medicaid enrollees. In 2011, 42.4 million Medicaid enrollees (74 percent of the overall Medicaid population) were enrolled in some form of managed care.[1] Historically, Medicaid managed care programs enrolled mostly children and families; however, many states are expanding their Medicaid managed care programs to include additional populations such as individuals with disabilities and individuals who are dually eligible for Medicare and Medicaid. In addition, managed care is likely to be critical to the way in which many states implement Medicaid eligibility expansions under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).

States have incorporated managed care into their Medicaid programs for a number of reasons. Although some states initially pursued Medicaid managed care to achieve rapid savings, such savings proved elusive, especially in the short term.[2] Even so, managed care provides states with some control and predictability over future costs. Compared with fee for service (FFS), managed care can allow for greater accountability for outcomes and can better support systematic efforts to measure, report, and monitor performance, access, and quality. In addition, managed care programs may provide an opportunity for improved care management and care coordination. However, in some circumstances, FFS may still provide advantages for certain populations and in certain geographic areas.

This MAC*facts* describes the different types of Medicaid managed care arrangements, a brief history of managed care in Medicaid, and the most recent statistics on Medicaid managed care enrollment.

Types of Medicaid Managed Care Arrangements

The term "managed care" may refer to a number of different arrangements for delivering and financing health care services. State Medicaid programs are now using three main types: comprehensive risk-based managed care, Primary Care Case Management (PCCM), and limited-benefit plans. These models differ in design, operation, and benefits covered (Box 1).

Comprehensive risk-based managed care. In comprehensive risk-based arrangements, states contract with managed care plans to cover all or most Medicaid-covered services for their Medicaid enrollees. Plans are paid a capitation rate, a fixed dollar amount per member per month, to cover a defined set of services. Although plans are responsible for providing or arranging for a majority of an enrollee's medical needs, the state is still obligated to ensure that Medicaid beneficiaries

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are provided appropriate health services. Plans are at financial risk if spending on benefits and administration exceeds payments; conversely, they are permitted to retain any portion of payments not expended for covered services and other contractually required activities. Many state Medicaid managed care programs have one or more benefits—such as behavioral health services, oral health services, nonemergency transportation, or prescription drugs—that are "carved out" and provided separately through FFS or by limited-benefit plans (described below).

PCCM. In a PCCM program, enrollees have a designated primary care provider who is paid a small monthly case management fee, such as $3, to assume responsibility for managing and coordinating their basic medical care. Individual providers are not at financial risk in PCCM programs; they continue to be paid on a FFS basis. Several states have enhanced their PCCM programs in an effort to improve outcomes by targeting more extensive care monitoring and chronic illness management to specific enrollees with high levels of need, and by incorporating performance and quality measures and financial incentives for providers.

Limited-benefit plans. Most states contract with limited-benefit plans to manage specific benefits or to provide services for a particular subpopulation. Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs) are defined as limited-benefit plans. PIHPs most frequently focus on providing inpatient mental health or combined mental health and substance abuse inpatient benefits. Typically, PAHPs cover one type of service such as transportation, oral health, or disease management. Both PIHPs and PAHPs are generally paid on a capitated basis, may be risk-based, and may be used to provide a set of services to FFS enrollees, managed care enrollees, or both.

The Evolution of Managed Care within Medicaid

Medicaid has evolved from an entirely FFS program to one where managed care plays a dominant role. The first statutory authority used to implement managed care in Medicaid actually predated the program's 1965 passage. The Public Welfare Amendments of 1962 (PWA 1962, P.L. 87-543) created Section 1115 of the Social Security Act, providing the federal government with authority to grant waivers on a demonstration basis for broad, structural changes to federal aid programs operated by states. This change allowed states to limit Medicaid enrollees' freedom of choice of participating providers and mandate managed care enrollment.

The Omnibus Reconciliation Act of 1981 (OBRA 1981, P.L. 97-35) created Section 1915(b) waivers that permit states to pursue mandatory managed care for enrollees in a certain geographic area, for certain populations, or otherwise limit individuals' choice of providers under Medicaid. The legislation also included controls on programs created with waiver authority to address some of the problems that were seen in early Medicaid managed care programs, including controversies that arose around questionable marketing practices, poor delivery systems, and plan financial stability.[3] OBRA 1981 required that Medicaid capitation rates be actuarially sound, and mandated that in order to be approved by the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services), the waiver could not restrict emergency care, substantially impair access to and quality of medical care, or discriminate against enrollees based on health status.

In 1993, states began increasing their use of Section 1115 research and demonstration waiver authority to shift mothers and children enrolled in Medicaid into mandatory managed care, enroll beneficiaries in plans that served a predominately Medicaid population, and expand coverage to new groups of low-income individuals and families.[4] Around this time, some states moved to implement

BOX 1. Overview of Medicaid FFS and Medicaid Managed Care Arrangements[1]

Key System Features	FFS	Comprehensive Risk-Based Plans	PCCM Programs	Limited-Benefit Plans[2]
Provider participation requirements	Any willing provider licensed by the state who agrees to accept Medicaid rates as payment in full can participate.	Plans must meet network size and location standards. Plans are permitted to limit the number of providers in their network and generally must credential providers before accepting them into the network.	PCCM providers may have to meet additional state requirements and agree to certain service policies.	Plans contract with a network of providers, similar to the process for comprehensive risk-based managed care plans, and may also need to meet network requirements.
Enrollee care-seeking rules	Typically, enrollees may receive care from any participating provider.	Plans set the rules on non-emergency referrals and care management, subject to state requirements and oversight. Services must be received from participating network providers, except in emergencies.	Enrollees may need referral by the primary care physician to see various kinds of specialists, except in emergencies.	Plans set the rules on non-emergency referrals and care management, subject to state requirements and oversight. Services typically must be received from participating network providers, except in emergencies.
Navigation support for enrollees	Open access; enrollees may or may not have rules or guidance on how or where to seek appropriate available services.	Plans typically must provide enrollees with a member handbook and conduct an initial health assessment to determine enrollee needs. Many also provide disease management and care coordination services.	PCCM programs may provide additional navigation support and ways of identifying appropriate providers.	Depending on the type of services provided, plans may provide navigation support for enrollees similar to comprehensive risk-based plans.
Performance monitoring and quality oversight	Provider accountability for outcomes for individual enrollees is not typically formalized. For example, most states do not require providers to report HEDIS data.[3]	Plans must conduct external quality reviews and must report specific performance data (e.g., HEDIS) and undertake specific quality improvement activities. Some states require external accreditation (e.g., NCQA and URAC).[4]	Same as FFS; potentially specific metrics associated with monitoring PCCM performance.	PIHPs must conduct annual external quality reviews, may be required to report performance data applicable to the services delivered, and undertake specific quality improvement activities.[5] External accreditation may be required.

[1] Some states have contracted with vendors to administer elements of their programs. Known as administrative services organizations (ASOs), these vendors are typically paid a non-risk-based fee to provide administrative services. Although they are not defined within federal statute or regulations, depending on how they are structured, ASOs may or may not be classified as a managed care arrangement.

[2] Limited-benefit plans may have all, some, or none of the elements of the key system features listed above, depending on the benefits covered and type of contracting arrangement with a state. For example, state contracts with limited-benefit plans for providing behavioral health or oral health services may include requirements regarding network development, assistance to enrollees seeking services, and development of member materials.

[3] HEDIS is Healthcare Effectiveness Data and Information Set.

[4] NCQA is National Committee for Quality Assurance, and URAC is the organization formerly known as the Utilization Review Accreditation Commission.

[5] PAHPs are not required to conduct an external quality review.

statewide managed care programs with ambitious deadlines, resulting in problems with developing adequate provider networks, educating beneficiaries on managed care, updating data systems, and ensuring sufficient oversight. However, by 1997 the federal government had approved 14 Medicaid statewide waivers, with a total enrollment of 8 million enrollees in mandatory managed care.[5]

The Balanced Budget Act of 1997 (BBA, P.L. 105-33) made it possible for states to implement mandatory managed care enrollment through amendments to their state plans, rather than just through waivers, with the exception of persons dually enrolled in Medicare and Medicaid, American Indians, and children with special needs. In exchange, states were required to meet specific managed care program requirements with regard to access standards, quality monitoring, and appropriateness of care. The legislation also allowed for the creation of Medicaid-only plans by repealing the "75/25" rule that had required plans to have a minimum share of private insurance enrollees. The "75/25" rule had replaced the "50/50" rule of the Health Maintenance Organization Amendments of 1976 (HMOA 1976, P.L. 94-460), which had been enacted in response to widespread marketing abuses and diversion of federal Medicaid funds by managed care plans with a large percentage of Medicaid enrollees in California.[6]

Enrollment in Medicaid Managed Care

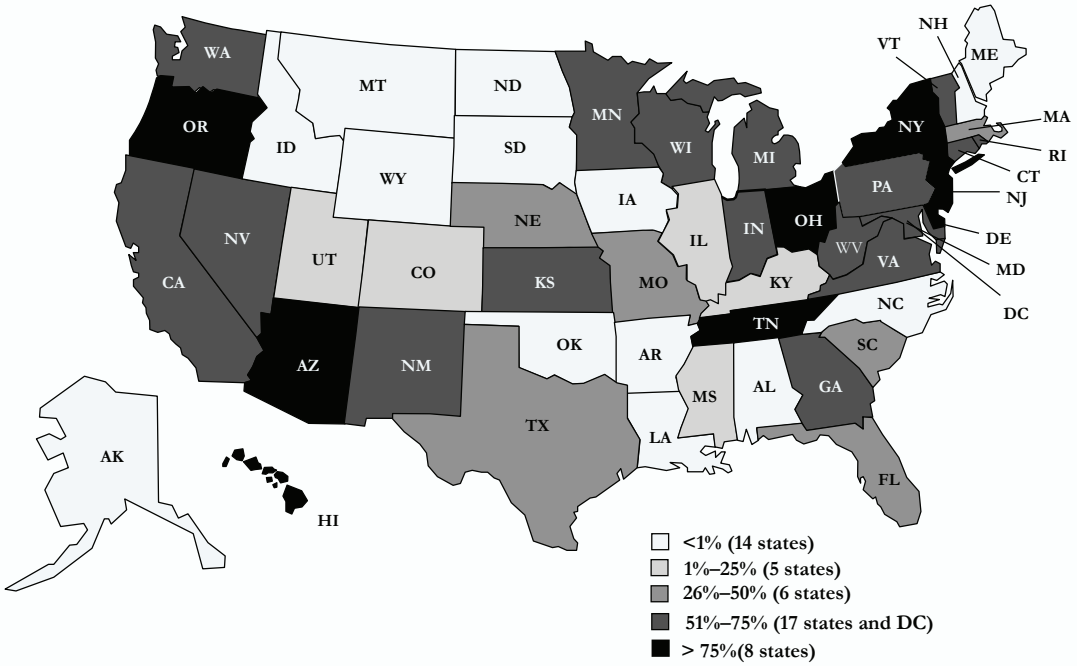
In 2011, 74 percent of all Medicaid enrollees received at least some kind of service through managed care.[7] Except for Alaska, New Hampshire, and Wyoming, all states used at least one form of managed care to provide services to their Medicaid enrollees in 2011. Two-thirds of Medicaid enrollees were in either a comprehensive risk-based managed care plan or a PCCM program.[8]

Although most states have primarily enrolled low-income children and their parents into Medicaid managed care, a growing number are using or actively considering managed care for populations with more extensive health needs, including persons with disabilities. There is also growing interest in using managed care programs for individuals dually enrolled in Medicaid and Medicare. In 2011, 10.5 percent of dual eligible enrollees, representing about 923,000 individuals, were enrolled in a comprehensive Medicaid managed care program. As of February 2013, 21 states were pursuing Financial Alignment Demonstrations with the Centers for Medicare & Medicaid Services to enroll their dual-eligible populations in managed FFS or capitated managed care plans. This approach seeks to integrate benefits and align financial incentives between the two programs.

Comprehensive risk-based managed care has been and continues to be the most common model of managed care for Medicaid enrollees. In 1995, 15 percent of Medicaid enrollees were enrolled in such an arrangement. By 2011, half of all Medicaid enrollees were enrolled in a comprehensive risk-based plan. As shown in Figure 1, 37 states and the District of Columbia operated comprehensive risk-based managed care in 2011. The 25 states (plus the District of Columbia) with more than half of their Medicaid populations in comprehensive risk-based managed care were mainly concentrated in the East Coast, West Coast, and the upper Midwest. Eight states had 75 percent or more of their Medicaid enrollees in comprehensive risk-based models.

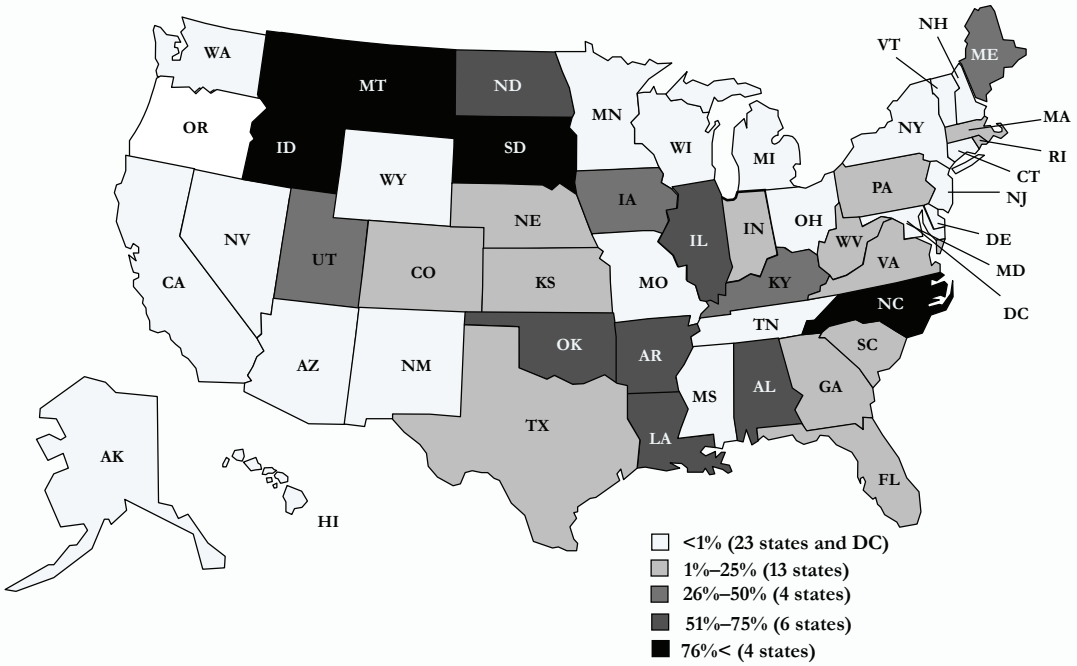
As of February 2013, 21 states operated PCCM programs with an enrollment of 8.9 million. Ten states had more than 50 percent of their enrollment in PCCM programs in 2011 (Figure 2). Some states have used PCCM programs in rural areas when they have had difficulties attracting and retaining comprehensive risk based plans to serve those areas. Twenty states had both comprehensive risk-based programs and PCCM programs.

FIGURE 1. Percentage of Medicaid Enrollment in Comprehensive Risk-Based Plans by State, 2011



Note: Includes CHIP enrollees in Medicaid-expansion programs but not stand-alone programs. Comprehensive risk-based includes plans categorized by CMS as commercial managed care plans, Medicaid-only plans, Health Insuring Organizations (HIOs), and the Program for All-Inclusive Care for the Elderly (PACE). HIOs exist only in California where Medicaid supports selected county-organized health systems. The PACE program combines Medicare and Medicaid financing for qualifying frail elderly dual eligibles.
SOURCE: MACPAC analysis of CMS 2011 Medicaid Managed Care Enrollment Report Summary Statistics as of July 1, 2011.

FIGURE 2. Percentage of Medicaid Enrollment in PCCM by State, 2011



Note: Includes CHIP enrollees in Medicaid-expansion programs but not stand-alone programs.
Source: MACPAC analysis of CMS 2011 Medicaid Managed Care Enrollment Report Summary Statistics as of July 1, 2011.

The trend toward significant managed care expansions and the forthcoming expansion of Medicaid eligibility in 2014 underscores the need for more research and analysis on the impact of Medicaid managed care on spending, access, and quality of care for beneficiaries, especially those who have complex chronic conditions and disabilities.

Two recent Commission efforts currently underway to inform these issues are a review of state managed care enrollment policies for different subpopulations, and an examination of the range and variety of approaches that states are using to set rates for managed long-term services, support services, and integrated care programs for the dual-eligible population. Moving forward, the Commission intends to track efforts to evaluate which managed care arrangements work best for populations now and in the future; to assess the impact of new service delivery models and purchasing strategies that link payment to performance, quality, and outcomes; and to examine how states coordinate Medicaid managed care with their state insurance exchanges.

For more information on this topic, see MACPAC's June 2011 *Report to the Congress: The Evolution of Managed Care in Medicaid.*

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[1] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2012. *2011 Medicaid managed care enrollment report*. Summary Statistics as of July 1, 2011. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf.

[2] Gold, M., and J. Mittler. 2000. Second generation Medicaid managed care: Can it deliver? *Health Care Financing Review* 22, no. 2: 29–47.

[3] Freund, D., and R. Hurley. 1995. Medicaid managed care: Contribution to issues of health reform. *Annual Review of Public Health* 16: 473–495.

[4] Rowland, D., and K. Hanson. 1996. Medicaid: Moving to managed care. *Health Affairs* 15, no 3: 150–152. http://content.healthaffairs.org/content/15/2/150.full.pdf.

[5] Smith, D., and J. Moore. 1998. *Medicaid politics and policy, 1965–2007*. New Brunswick, NJ: Transaction Publishers.

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[7] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2012. *2011 Medicaid managed care enrollment report*. Summary Statistics as of July 1, 2011. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf.

[8] The Centers for Medicare & Medicaid Services' Medicaid managed care enrollment statistics include State Children's Health Insurance Program enrollees who are covered through Medicaid-expansion programs but not enrollees in separate stand-alone programs. The Centers for Medicare & Medicaid Services reported unduplicated managed care enrollment, which includes enrollees receiving comprehensive benefits and limited benefits, of 42.4 million. This figure includes individuals who were enrolled in more than one managed care plan and individuals enrolled in state health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards.